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Collaborating on Cancer Care

By Michael Misialek

Commenting in response to the JAMA article published in March 2015 on diagnostic concordance among pathologists interpreting breast biopsy specimens (1)...

The major challenge in diagnosing the potential for breast cancer at the premalignant stages lies in recognizing it. In many cases, needle biopsy does a good initial job by allowing the pathologist to

properly triage the patient and identify a lesion that's better examined with an excisional biopsy. Practices that don't do secondary prospective review of problematic cases face an additional obstacle to diagnosis; this is critical for high quality work and I would personally consider it mandatory. A robust quality management program that includes specific criteria for mandatory prospective review of complex cases – things that will result in significant clinical impact – is imperative to render quality, reproducible diagnoses. One final challenge that may exist for some practices is the lack of a "team effort" by collaborating clinicians. It's imperative for pathologists to have access to other treating clinicians like radiologists, oncologists, and surgeons. No field of medicine can practice in isolation.

Since the JAMA study was heavily weighted towards "grey area" diagnoses of atypical hyperplasia and DCIS, I suspect that differences of opinion among pathologists were magnified. Despite diagnostic criteria separating these two categories, many cases prove difficult to classify and even experts sometimes disagree. These diagnoses form a spectrum along which the lines of separation are often blurred, and the definitions pathologists use can vary depending upon their training. These "grey area" diagnoses illustrate that pathology is more than just a science – it's an art that requires experience and developing an "eye."

Pathologists have a lot of tools available for studying complex cases. Perhaps most important of all is the power of second opinions. My first step, for instance, is often showing my slides to a colleague, something that occurs countless times a day in many pathology practices. Others might start with ordering additional, "deeper" levels of slides to better evaluate the tissue. Immunohistochemical stains might also prove useful in particular cases. If, after all of these steps, a consensus diagnosis is not reached, then the case will be sent out for outside expert consultation – which again illustrates the importance of collaborative care.

> "These diagnoses form a spectrum along which the lines of separation are often blurred…"

The concern raised by media attention on the JAMA paper and other recent studies provides an excellent opportunity for pathologists to educate the public about our field, and about the importance of pathology in their care and education about disease. Impressing upon patients the value of pathology and stressing the need for multidisciplinary collaborative care is important. We should capitalize on this opportunity and use it not only to bring awareness to the field, but to engage patients more deeply in their own care.

I'd like to tell women that these recent studies should in no way dissuade them from breast cancer screening. We know that screening for disease is the best way to find cancer or precancerous conditions in the early stages when they are still highly curable. Patients should understand that

board certified pathologists who work in accredited laboratories are excellent diagnosticians and ensure the highest quality in their care. And patients are healthier when pathologists are involved with their care. Many pathologists already regularly meet with patients – let's open the doors for all of us to invite our patients to meet us.

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Reference

1. JG Elmore, et al., "Diagnostic concordance among pathologists interpreting breast biopsy specimens", JAMA, 313, 1122–1132 (2015). PMID: 25781441.

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